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A LIAISON PSYCHIATRIST ON THE CORONARY CARE UNIT.(U)
1974 R H RAHE

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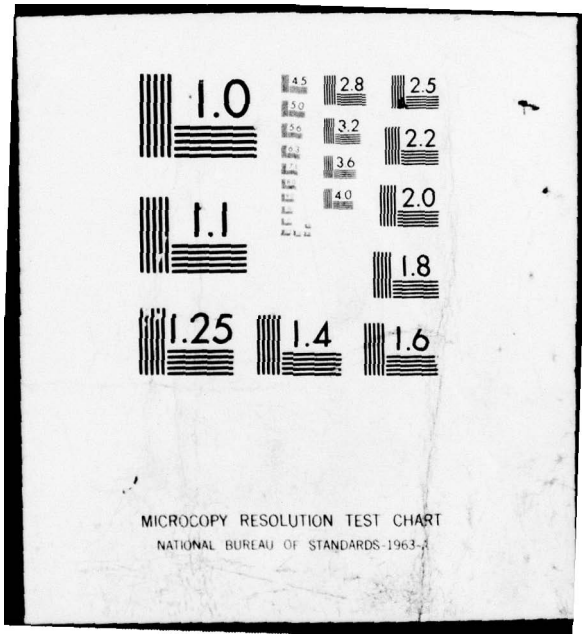
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A LIAISON PSYCHIATRIST ON THE CORONARY CARE UNIT

R. H. RAHE

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This paper gives examples of the initial difficulties and subsequent rewards experienced by the psychiatrist performing a liaison role on the coronary care unit. Once the psychiatrist avoids the pitfalls inherent in his first weeks on the service, he will find that not only is he asked to make day-to-day contributions to patient care, but also to provide input to ward policy and also to help design research investigations. The author's experience in these areas is presented.

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Richard H. Rahe

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A Liaison Psychiatrist on the Coronary Care Unit

As the field of medicine becomes increasingly complex, areas of specialization naturally arise. This volume illustrates that the trend toward specialization is evident in the field of psychiatric consultation today. Traditionally, departments of psychiatry designated a few residents and a part-time staff member to cover requests for psychiatric consultations arising from the general hospital inpatient, outpatient, and emergency room services. These psychiatric consultants spent their time racing from one end of the hospital to the other to see patients in some type of crisis. The consultants generally obtained little longitudinal follow-up on the patients they saw. In contrast, a specialization of the psychiatrist's experience to a single hospital area allows him to develop interviewing skills and therapeutic programs for a restricted range of patients—and thus he soon develops expertise. In these specialized hospital settings opportunities for patient follow-up are excellent.

It is of some interest to note that the hospital areas that afford the liaison psychiatrist greatest opportunities for service and research are those areas of highly developed medical or surgical technology. Coronary care units, intensive (surgical) care units, renal dialysis centers, burn units, and rehabilitation services are all examples of such areas. It seems that in these centers of technological sophistication patients' human needs are apt to be ignored. In ad-

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dition, the variety of physiological measurements routinely made on patients in these centers provides the liaison psychiatrist a ready opportunity to study psychophysiological phenomena.

This chapter has two aims—first, to present some important guidelines for the novice liaison psychiatrist (if the psychiatrist gets off on the "wrong foot" in his liaison role, he will experience significant difficulties achieving his potential in service and research) and, second, to give some examples of useful contributions that can be made by the liaison psychiatrist in terms of patient care and research. Though the topic is the liaison psychiatrist on the coronary care unit (CCU), many of the guidelines presented are equally applicable to a liaison psychiatrist working in other specialized centers of care in the hospital.

GUIDELINES FOR THE FIRST DAYS ON THE UNIT

You Must Know All Aspects of The Service

Prior to starting his CCU service, the liaison psychiatrist should first meet with the medical director of the unit and request an introduction to the service much as would be done if he (the psychiatrist) were a third-year medical student. This approach allows the psychiatrist to be brought up to date on the technical advances that have occurred since he was last on a medical ward. In addition it allows him a few days of strict orientation without any expectations placed upon him to provide expert opinion.

During his orientation the psychiatrist should observe and note key interpersonal relationships with which he must subsequently deal. For example, the senior physician–junior nurse relationship is frequently a mutually satisfying one characterized by a technically knowledgeable, competent, and somewhat paternal cardiologist dealing in a kindly, teaching fashion with young, bright, receptive nurses. The senior nurse–junior physician relationship, however, can pose some problems. As the senior nurse is frequently a highly trained and extremely competent specialist (in contrast to her more administrative-minded senior nurse counterpart on the medical wards), she is frequently frustrated by the constant influx of interns and junior residents in need of training. To make matters worse, these junior physicians often spend but four to six weeks on the CCU before rotating to another service. Thus, the senior nurses may see these physicians as short-term intruders with an enormous potential for interfering with the smooth and competent functioning of the service.

It is extremely important that the liaison psychiatrist pay particular attention to the rounds schedule and other teaching sessions carried out on the CCU.

Early morning rounds are *the best time* for the psychiatrist to meet with the full medical ward staff, to become acquainted with newly admitted patients, and eventually to make pertinent suggestions regarding psychological aspects of patients with coronary heart disease (CHD). On occasion, the psychiatrist will identify problem-laden and/or potentially troublesome patients on the morning rounds. He can then interview these patients later that day, without waiting for a crisis to develop and formal psychiatric consultation to be requested.

In Order to Teach, You Must Be Prepared to Learn

A crucial question the liaison psychiatrist should ask himself before offering his services on a CCU is whether or not he is truly interested in what is being done there. Once the liaison psychiatrist shows an interest to learn, it is an easy step for him subsequently to offer to share his psychiatric knowledge with the CCU staff. A further reason that he should be conversant with the medical interests of personnel on the CCU is so that he can impart to the staff psychiatric concepts phrased in their "language." For example, rather than saying "I feel this patient's unresolved hostility may interfere with his treatment plan," the liaison psychiatrist might "translate" such a statement as follows: "Think of the effect on this patient's norepinephrine output if he continues to feel so angry."

To achieve acceptance by the CCU staff, the liaison psychiatrist does not need to have literally a stethoscope dangling from his pocket. However, he should consider the nonverbal communication implied by his appearance. The fact that many departments of psychiatry allow their residents to dress as if they were about to embark on a fishing trip has little bearing on how the liaison psychiatrist should appear on the CCU. If a shirt, tie, and a white lab coat are included in the standard of dress on the CCU, it is advisable to follow suit if the psychiatrist wishes to deal readily with staff, patients, and relatives.

See the CCU from the Patient's Perspective

Staff–patient interactions are largely influenced by how the patient perceives his illness. Patients with CHD have been described by several authors to show a notable capacity for minimizing, repressing, and otherwise ignoring the significance and limitations of their illness.[1, 2, 3, 4] Such patients are frequently labeled "uncooperative" by the nurses; they resist following orders, will not remain at bed rest during the early stages of their illness, and frequently wish to carry on their usual business and personal transactions while on the unit. In addition, patients on the CCU are generally males in their forties and fifties who

receive close, daily, physical care from young, often attractive, female nurses. Problems related to patient or staff sexual tensions frequently occur.

Much of the patient's behavior is understandable once the psychiatrist views the CCU experience from the patient's point of view. Rather than being "uncooperative," patients are often trying to show self-sufficiency. Overt flirtations may serve to repress thoughts of their recent brush with death. Of major interest is the finding that this "denial" of illness by some patients is associated with lower morbidity rates than that seen for "nondeniers."[5]

Spending time with CCU patients during interviews opens the psychiatrist's eyes to the several inconveniences that patients experience—such as daily weighings, blood draws, medication schedules, rounds, and on and on. Many of these routines are timed for the convenience of the staff (like weighings at 5:00 A.M.) rather than for the patient. Reasons for daily blood draws and medication changes are often not given to the patient. For patients who like efficiency and explanation the CCU can be a very frustrating environment.

Beware of Nurses

The liaison psychiatrist should be alert in his dealings with the CCU nurses. To be an effective counselor when nurse–physician problems arise, the psychiatrist should strive to remain objective. Frequently nurses will invite the psychiatrist to attend nursing conferences where personnel problems are discussed. At first this seems a good chance for the psychiatrist to exercise his group therapy skills. Later, however, the nurses may ask him to carry their problems to the medical staff. Worse yet, he may find himself being "quoted" by senior nurses to younger, more independent-minded nurses, in order to keep them in line. On the other hand, the psychiatrist–nurse relationship is central to much of the success of the liaison psychiatrist. The nurses are the ones who generally have to deal with patients' psychological problems. They are also the ones who carry out the psychiatrist's suggestions on patient management. Thus, the psychiatrist should strive to develop rapport with the nurses, but he should beware of becoming their agent.

CONTRIBUTIONS TO PATIENT CARE AND RESEARCH

Patient Care

The psychiatrist will soon become engaged in the day-to-day problems of patient care. In the recent past a liaison psychiatrist had to deal with patients' psychological problems regarding their adjustment to the unusual surroundings

of a CCU. Such problems of patient adjustment have undergone remarkable dimunition since 1960 with modernization of the CCU and with increased use of tranquilizing medications.

When coronary care units were first instituted in the general hospital, a few beds and a great deal of electronic cardiac monitoring equipment were frequently crowded into an out-of-the-way corner on a medical ward. Two to four patients shared the same room, and the proximity of patients and staff made the problems of one quickly apparent to the other. Cardiac emergencies were a frenzy of activity and patients were constantly reminded of the potential lethality of their disease.[5] Psychological problems of patients in these early CCUs have all but disappeared in the relatively spacious, modern CCUs of today. Patients frequently have private rooms and are relatively isolated from emergency medical procedures required by other CCU occupants. In addition, patients spend fewer days on the CCU prior to their transfer to the ward than was previously the case. Perhaps most important in reducing psychological problems of acute cardiac patients has been the trend for cardiologists to prescribe relatively high doses of tranquilizing medications. Thus, CCU patients spend their two to three days on the unit in a state of drowsiness very close to sleep. Patients medicated in this way are often amnesic for their CCU stay when later interviewed on the ward.

With some exceptions, the liaison psychiatrist will normally meet with cardiac patients after they have medically stabilized and are ready for transfer to the ward. Most of the patients will have suffered a myocardial infarction (MI), a disease entity about which these patients have little knowledge. The psychiatrist may find himself the recipient of several questions concerning this illness. For example, patients may wish an explanation in lay terms of "what is a heart attack." They may express concern about routine blood draws, emergency oxygen equipment, enforced bed rest, and so forth. To answer these questions systematically, it is best to assemble some type of a CHD information booklet. Anatomical illustrations of the heart and the coronary arteries can be included in order to talk meaningfully to the patient about his disease. Separate sections of the booklet should deal with CCU emergency equipment, diet, and smoking, the gradual resumption of physical activity following a MI, and so forth. The liaison psychiatrist could add a separate section dealing with persons' life stress and behavior characteristics associated with CHD.[4, 6, 7]

There are several benefits of such a CHD booklet. Patients receive a consistent, systematized presentation of information important for their rehabilitation. They can study the booklet at their own pace. The booklet encourages patient-staff interactions in terms of asking questions and assessing comprehension of the material. The booklet can also be given to the patient's spouse or near relative for his or her educational needs. Finally, the booklet tends to emphasize that several, rather than just one or two, physical and psychological ad-

justments are required for optimal rehabilitation from MI.

Research

Another attraction of the liaison psychiatrist experience in the CCU is the ample opportunities for the psychiatrist to become involved in research. Research problems that invite psychiatric attention are those of patient (and family) education and longitudinal studies of efforts toward rehabilitation. For example, on the CCU at the University of California Los Angeles University Hospital we wished to assess our patient education program, which utilized a CHD booklet. To accomplish this evaluation, a CHD teaching-evaluation questionnaire was created.[8] Questions were composed regarding what is a "heart attack," reasons for various CCU emergency equipment, potentially harmful dietary and smoking habits, resumption of physical activity following an MI, psychological factors important for persons with CHD, and problems related to returning home and to work following hospitalization. Patients were given the questionnaire immediately prior to receiving the CHD booklet—usually about the third hospital day. Analysis of the answers provided an estimate as to how much knowledge each patient had in these areas before receiving the booklet. The same questionnaire was readministered between the fourteenth and eighteenth hospital day, shortly prior to hospital discharge. These scores when compared to the scores for the first "test" helped us to evaluate how much had been learned from the booklet.[8]

When we analyzed the responses on both questionnaires for the first 25 patients, we discovered several areas where patient learning could be improved.[8] Despite a high degree of enthusiasm for the teaching program shown by both patients and staff, sections of the CHD booklet were not being read and/or understood. The results of this questionnaire study stimulated the staff to make several modifications in the patient education program. A dietition was invited to spend time on the ward and to hold occasional discussions with patients and their spouses. The liaison psychiatrist initiated patient and spouse group therapy discussions. A special rounds was started by the senior cardiologist and the nursing staff to discuss with the junior medical staff medical and psychological preparations of their patients for hospital discharge. A follow-up clinic was instituted where all discharged post-MI patients were scheduled to return for periodic checks on their understanding and compliance with rehabilitation schedules.

A second example of research inspired by work on CCUs was done at the U.S. Naval Hospital in San Diego.[7,9] This experiment consisted of establishing two randomly composed groups of discharged post-MI patients. Both groups of patients received identical medical follow-up care, but one group received in addition a series of six group therapy sessions over the first three months following hospital discharge.[7]

During the first few group therapy meetings patients were encouraged to discuss their recent life stress and illness patterns as well as to assess whether or not they displayed various behaviors and attitudes reportedly associated with CHD.[4, 6] As the series of group therapy sessions progressed, patients having difficulties complying with their rehabilitation regimens frequently became the focus of discussion. In addition, since the patients were recuperating at home for a month or more following hospital discharge, their relationships with family members became a common theme of discussion. Toward the end of the group therapy sessions, a few patients had resumed work. Here, it was appropriate for the group to search out ways in which these patients might avoid or modify previously identified work stresses and/or difficulties with colleagues. Group therapy subjects completed the CHD teaching evaluation questionnaire after their series of sessions. These patients showed significantly greater knowledge about an MI and optimal rehabilitation than did members of the control group who completed the same form.[9]

Group therapy and control patients have now been followed since 1972.[9] Follow-up data have included patients' readmissions to hospital for all causes. Group therapy patients have returned to the hospital for episodes of coronary insufficiency at one-third the rate seen for control group patients. In terms of reinfarction, group therapy subjects have experienced one-fifth the reinfarction rate seen for control subjects. Follow-up interviews also evaluate various "softer" criteria for successful rehabilitation, such as incidence and prevalence rates for angina pectoris, medication usage, return to work percentages, and psychological adjustment.

IN CONCLUSION

This chapter presents examples of both initial difficulties and subsequent rewards peculiar to the liaison psychiatrist experience. If the psychiatrist can avoid early pitfalls inherent in this specialized experience, his potential for patient care and research experience greatly exceeds that which he might obtain through the conventional psychiatric consultant experience. As a specialized liaison psychiatrist, he rapidly develops diagnostic and therapeutic expertise that comes from seeing a restricted type of patient. Aside from soon making day-to-day contributions in patient care, the liaison psychiatrist may eventually help shape ward policy and design research investigations important in the longitudinal care of postinfarction patients.

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